

Infection – Management and Treatment in Primary Care SWL (Antimicrobial Guidelines)

For use in NHS Sutton, Merton, Wandsworth, Kingston & Richmond boroughs

This guidance is based on the best available evidence but use professional judgement and involve patients

PRINCIPLES OF TREATMENT

1. This guidance should not be used in isolation; it should be supported with patient information about safety netting, delayed/back-up antibiotics, self-care, infection severity and usual duration, clinical staff education, and audits. Materials are available on the [RCGP TARGET](#) website.
2. Prescribe an antibiotic only when there is likely to be a clear clinical benefit, giving alternative, non-antibiotic self-care advice, where appropriate. Limit telephone prescribing to exceptional cases.
3. Always check for antibiotic allergies. Confirm true allergy (i.e. rash, swelling of lips, tongue or face, anaphylaxis, etc.) to recommended antibiotic before prescribing an alternative to ensure appropriate antibiotics are not excluded from the options.
4. Consider a no, or delayed/back up, antibiotic strategy for acute self-limiting upper respiratory tract infections and mild UTI symptoms.
5. In severe infection, or immunocompromised, it is important to initiate antibiotics as soon as possible, particularly if sepsis is suspected. If the patient is not at moderate to high risk for sepsis, give information about symptom monitoring, and how to access medical care if they are concerned.
6. Where an empirical therapy has failed or special circumstances exist, microbiological advice can be obtained from St George's Hospital on ☎ 0208 725 5693, Kingston Hospital on ☎ 020 8934 2052 or St Helier Hospital on ☎ 020 8296 2468.
7. Use simple generic antibiotics first if possible. Avoid broad spectrum antibiotics (e.g. co-amoxiclav, quinolones and cephalosporins) when narrow spectrum antibiotics remain effective, as they increase the risk of *Clostridium difficile*, MRSA and resistant UTIs.
8. Modify suggested adult doses/duration for age, weight and renal function. Consider a larger dose or longer course in severe or recurrent cases. Doses are for guidance only, are oral and for adults unless otherwise stated. Children's doses are provided when appropriate and can be accessed through the [BNFc](#) symbol. Refer to the BNF for further dosing and interaction information (e.g. interaction between macrolides and statins, clozapine and ciprofloxacin, etc) if needed. Check for hypersensitivity.
9. The use of new and more expensive antibiotics (e.g. quinolones and cephalosporins) is inappropriate when standard and less expensive antibiotics remain effective.
10. Lower threshold for antibiotics in immunocompromised or those with multiple morbidities; consider culture/specimens and seek advice.
11. Avoid widespread use of topical antibiotics, especially those agents also available systemically; in most cases, topical use should be limited.
12. In pregnancy take specimens to inform treatment. Where possible AVOID tetracyclines, aminoglycosides, quinolones, azithromycin (except in chlamydial infection), clarithromycin, and high dose metronidazole (2g STAT), unless benefits outweigh the risks. Penicillins, cephalosporins and erythromycin are safe in pregnancy. Short term use of nitrofurantoin is not expected to cause foetal problems (theoretical risk of neonatal haemolysis). Trimethoprim is also unlikely to cause problems unless poor dietary folate intake, or taking another folate antagonist. Seek further advice from the [UK Teratology Information Service](#) on ☎ 0344 892 0909 if needed.
13. Avoid all tetracyclines in children under 12 years due to deposition in growing bone and teeth, by binding to calcium, causing staining and occasionally dental hypoplasia.
14. Where there are two clinically appropriate options consider adherence and cost effectiveness.
15. Disabling, long-lasting or potentially irreversible adverse reactions affecting musculoskeletal and nervous systems have been reported very rarely with fluoroquinolone antibiotics. Fluoroquinolone treatment should be discontinued at the first signs of a serious adverse reaction, including tendon pain or inflammation. For further information click [here](#).

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by [BNFc](#)) for further information.

Lead author: SW London Infection Network for use in NHS Sutton, Merton, Wandsworth, Kingston & Richmond boroughs.

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South West London

ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
UPPER RESPIRATORY TRACT INFECTIONS NICE NG63: Consider delayed antibiotic prescriptions. Do not prescribe antibiotics for viral sore throat, simple coughs & colds.				
Acute sore throat NICE: Sore throat (acute) NG84 NG84 Visual summary	No antibiotic. Give self-care advice – see comments section.			Self-care advice: - Paracetamol/ibuprofen for pain. - Medicated lozenges may help pain in adults and can be bought OTC. - Drink adequate fluids. - Explain soreness will take about 7 days to resolve and safety net. Self Care Forum Factsheet Avoid antibiotics as 82% of cases resolve in 7 days, and pain is only reduced by 16 hours. - Use FeverPAIN or Centor to assess symptoms. FeverPAIN 0-1 or Centor 0-2: No antibiotic FeverPAIN 2-3: No antibiotic or back up antibiotic FeverPAIN 4-5 or Centor 3-4: immediate or back-up antibiotic Systemically very unwell or high risk of complications: immediate antibiotic - Complications are rare: antibiotics to prevent quinsy NNT>4000; otitis media NNT200. 10 days penicillin has lower relapse than 5 days in patients under 18 years of age.
	1. Penicillin V	500mg QDS/1g BD ^{BNFc}	5-10 days	
	Penicillin allergy:			
	Clarithromycin	250-500mg BD ^{BNFc}	5 days	
	OR			
	Erythromycin (preferred if pregnant)	250-500mg QDS/500mg-1g BD ^{BNFc}	5 days	
Scarlet fever (Group A Streptococcus) PHE Scarlet fever	Optimise analgesia, give safety netting advice AND:			Self-care advice: - Paracetamol/ibuprofen for pain. - Drink adequate fluids. Prompt treatment with appropriate antibiotics significantly reduces the risk of complications. Vulnerable individuals (immunocompromised, the comorbid, or those with skin disease) are at increased risk of developing complications. CKS: Offer paracetamol or ibuprofen, encourage rest and to drink adequate fluids. CKS: Scarlet fever is a notifiable disease. If there is any suspicion of infection because of clinical features, a notification form should be completed and sent to the local UK Health Security Agency (UKHSA) centre within 3 days.
	Penicillin V	500mg QDS ^{BNFc}	10 days	
	Penicillin allergy:			
	Clarithromycin	250-500mg BD ^{BNFc}	5 days	
Acute sinusitis NICE: Sinusitis (acute) NG79 NG79 Visual summary	No antibiotic. Give self-care advice – see comments section.			Self-care advice: - Paracetamol/ibuprofen for pain/fever. - Little evidence that nasal decongestants or nasal saline help, but people may want to try them. Symptoms <10 days: do not offer antibiotics as most resolve in 14 days without, and antibiotics only offer marginal benefit after 7 days (NNT15). Symptoms with no improvement >10 days: no antibiotic, or delayed antibiotic if several of: - purulent nasal discharge; - severe localised unilateral pain; - fever; - marked deterioration after initial milder phase. - Consider high-dose nasal steroid if >12 years. Systemically very unwell, or high risk of complications: immediate antibiotic. Suspected complications: e.g. sepsis, intraorbital or intracranial, refer to secondary care. CKS: Explain that acute sinusitis is caused by a virus in more than 98% of people, takes on average 2.5 weeks to resolve, and that antibiotics are only likely to help when there are features indicative of bacterial infection.
	1. Penicillin V	500mg QDS ^{BNFc}	5 days	
	Penicillin allergy:			
	Doxycycline (not in under 12yrs) OR	200mg STAT then 100mg OD ^{BNFc}	5 days	
	Clarithromycin OR	500mg BD ^{BNFc}	5 days	
	Erythromycin (preferred if pregnant)	250-500mg QDS ^{BNFc} OR 500-1000mg BD	5 days	
	Third choice or very unwell or worsening:			
Co-amoxiclav	500/125mg TDS ^{BNFc}	5 days		

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by ^{BNFc}) for further information.

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Acute Otitis Externa CKS Otitis externa	• No antibiotic. Give self-care advice – see comments section.			Self-care advice: • Analgesia for pain relief and apply localised heat (e.g. a warm flannel). • *EarCalm® available over the counter • Second line: topical acetic acid or topical antibiotic +/- steroid: similar cure at 7 days. • If cellulitis or disease extends outside ear canal or systemic signs of infection, start oral flucloxacillin and refer to exclude malignant otitis externa.						
	1. Acetic acid 2% (over 12 years only)*	1 spray TDS ^{BNFc}	7 days							
	2. Neomycin sulphate with corticosteroid	3 drops TDS ^{BNFc}	7 days (min) to 14 days (max)							
	If cellulitis:									
	Flucloxacillin	250mg QDS ^{BNFc} If severe: 500mg QDS	7 days 7 days							
Acute Otitis Media NICE: Otitis media (acute) NG91 NG91 Visual summary	Offer regular paracetamol or ibuprofen for pain.		Up to 7 days	AOM is a self-limiting infection that mainly affects children. It can be caused by a virus and bacteria and it is difficult to distinguish between these. However, both are usually self-limiting and do not routinely need antibiotics. Advise AOM lasts about 3 days but can be up to 1 week. Antibiotics make little difference to the number of children whose symptoms improve. Complications (e.g. mastoiditis) are rare with or without antibiotics. Optimise analgesia and avoid antibiotics Those with otorrhoea, or those aged less than 2 years with bilateral infection are more likely to benefit from antibiotics <table><tr><td>Systemically very unwell or high risk of complications:</td><td>Immediate antibiotic</td></tr><tr><td>Otorrhoea or under 2 years with infection in both ears:</td><td> • No antibiotics or • Back-up antibiotics or • Immediate antibiotic </td></tr><tr><td>Otherwise:</td><td> • No antibiotic or • Back-up antibiotic </td></tr></table> With immediate antibiotic, advise: Seek medical help if symptoms worsen rapidly or significantly. With back-up antibiotic prescription, advise: Antibiotic not needed immediately. Use prescription if no improvement in 3 days or symptoms worsen. Seek medical help if symptoms worsen rapidly or significantly. With no antibiotic given, advise: Antibiotic is not needed. Seek medical help if symptoms worsen rapidly or significantly.	Systemically very unwell or high risk of complications:	Immediate antibiotic	Otorrhoea or under 2 years with infection in both ears:	• No antibiotics or • Back-up antibiotics or • Immediate antibiotic	Otherwise:	• No antibiotic or • Back-up antibiotic
	Systemically very unwell or high risk of complications:	Immediate antibiotic								
	Otorrhoea or under 2 years with infection in both ears:	• No antibiotics or • Back-up antibiotics or • Immediate antibiotic								
	Otherwise:	• No antibiotic or • Back-up antibiotic								
	Consider eardrops containing anaesthetic and analgesic if an immediate oral antibiotic prescription is not given and there is no eardrum perforation / otorrhoea i.e				Up to 7 days					
	Phenazone 40mg/g with lidocaine 10mg/g (Otigo®)	Apply 4 drops two or three times a day								
	Amoxicillin	1-11 months: 125mg TDS ^{BNFc} 1-4 years: 250mg TDS 5-17 years: 500mg TDS	5-7 days							
	Penicillin allergy or intolerance:									
	Clarithromycin	1 month - 11 years: ^{BNFc} Under 8kg: 7.5mg/kg BD 8-11kg: 62.5mg BD 12-19kg: 125 mg BD 20-29kg: 187.5mg BD 30-40 kg: 250mg BD OR 12-17 years: 250-500mg BD	5-7 days							
	OR Erythromycin (preferred if pregnant)	8-17 years: 250-500mg QDS OR 500 – 1000mg BD	5-7 days							
Worsening symptoms on first choice taken for at least 2 to 3 days:										
Co-amoxiclav	1-11 months: 0.25 ml/kg of 125/31 suspension TDS ^{BNFc} 1-5 years: 5ml of 125/31 suspension TDS OR 0.25ml/kg of 125/31 suspension TDS 6-11 years: 5ml of 250/62 suspension TDS OR 0.15 ml/kg of 250/62 suspension TDS 12-17 years: 250/125mg TDS OR 500/125mg TDS	5-7 days								
Alternative second choice oral antibiotic for penicillin allergy or intolerance										
Consult local microbiologist										

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LOWER RESPIRATORY TRACT INFECTIONS Note: Low doses of penicillins are more likely to select out resistance, we recommend 500mg of amoxicillin. Do not use quinolones (ciprofloxacin and ofloxacin) 1 st line due to poor pneumococcal activity. Reserve all quinolones (including levofloxacin) for proven resistant organisms.				
Acute cough and bronchitis NICE: Cough (acute) NG120 NG120 Visual Summary	Give self-care advice & safety net – see comments section.			Self-care advice: - Some people may wish to try honey (in over 1s), the herbal medicine pelargonium (in over 12s), cough medicines containing the expectorant guaifenesin (in over 12s) or cough medicines containing cough suppressants, except codeine, (in over 12s). These self-care treatments have limited evidence for the relief of cough symptoms. Acute cough with upper respiratory tract infection: no antibiotic. Acute bronchitis: no routine antibiotic. Acute cough and higher risk of complications (at face-to-face examination): immediate or back-up antibiotic. Acute cough and systemically very unwell (at face to face examination): immediate antibiotic. - Higher risk of complications includes: - people with pre-existing comorbidity; - young children born prematurely; - people over 65 with 2 or more of, or over 80 with 1 or more of: - hospitalisation in previous year, - type 1 or 2 diabetes, - history of congestive heart failure, - current use of oral corticosteroids. - Do not offer a mucolytic, an oral or inhaled bronchodilator, or an oral or inhaled corticosteroid unless otherwise indicated. - Antibiotics have little benefit if no co-morbidity. Consider delayed antibiotic as second line, with safety netting, and advise that symptoms can last up to 3 to 4 weeks.
	Adults aged 18 years & over:			
	1. Doxycycline	200mg STAT then 100mg OD ^{BNFc}	5 days	
	Adults aged 18 years & over – alternative first choice antibiotics:			
	Amoxicillin OR (preferred if pregnant)	500mg TDS ^{BNFc}	5 days	
	Clarithromycin OR	250-500mg BD ^{BNFc}	5 days	
	Erythromycin (preferred if pregnant)	250-500mg QDS ^{BNFc} OR 500-1000mg BD	5 days	
	Children & young people under 18 years:			
	1. Amoxicillin	1-11 months: 125mg TDS ^{BNFc} 1-4 years: 250mg TDS 5-17 years: 500mg TDS	5 days	
	Children & young people under 18 years - alternative first choice antibiotics:			
Acute exacerbation of COPD NICE: COPD (acute exacerbation) NG114 NG114 Visual summary NICE COPD NG115	Clarithromycin	1 month - 11 years: ^{BNFc} Under 8kg: 7.5mg/kg BD 8-11kg: 62.5mg BD 12-19kg: 125 mg BD 20-29kg: 187.5mg BD 30-40 kg: 250mg BD OR 12-17 years: 250-500mg BD	5 days	
	OR			
	Erythromycin	1 month to 1 year: 125mg QDS ^{BNFc} OR 250mg BD 2-7 years: 250mg QDS OR 500mg BD 8-17 years: 250-500mg QDS OR 500 – 1000mg BD	5 days	
	OR			
	Doxycycline (not in under 12yrs)	200mg STAT then 100mg OD ^{BNFc}	5 days	
	1. Amoxicillin OR	500mg TDS (see BNF for severe infection)	5 days	
	Doxycycline OR	200mg STAT then 100mg OD (see BNF for severe infection)	5 days	
	Clarithromycin	500mg BD (see BNF for severe infection)	5 days	
	Second choice oral antibiotics if no improvement in symptoms on first choice taken for at least 2 to 3 days; guided by susceptibilities when available.			
	Alternative choice (if person at higher risk of treatment failure):			
	2. Co-amoxiclav OR	500/125mg TDS	5 days	- Many exacerbations are not caused by bacterial infections so will not respond to antibiotics. - Consider an antibiotic, but only after taking into account severity of symptoms (particularly sputum colour changes and increases in volume or thickness), need for hospitalisation, previous exacerbations, hospitalisations and risk of complications, previous sputum culture and susceptibility results, and risk of resistance with repeated courses. - Some people at risk of exacerbations may have antibiotics to keep at home as part of their exacerbation action plan.
	Co-trimoxazole (consider safety issues) OR	960mg BD	5 days	
	Levofloxacin (consider safety issues)	500mg OD	5 days	

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Acute exacerbation of Bronchiectasis NICE: Bronchiectasis (non-cystic fibrosis) (acute exacerbation) NG117 NG117 Visual summary	Adults aged 18 years & over Send a sputum sample for culture and susceptibility testing and start empirical treatment:			Do not await the results of culture. - When choosing antibiotics, take account of: severity of symptoms, previous exacerbations, hospitalisations and risk of complications and treatment failure, previous sputum culture and susceptibility results - If unable to take oral antibiotics or severely unwell refer to hospital for IV antibiotics. - Course length based on an assessment of the person's severity of bronchiectasis, exacerbation history, severity of exacerbation symptoms, previous culture and susceptibility results, and response to treatment. - People who may be at higher risk of treatment failure include people who have had repeated courses of antibiotics, a previous sputum culture with resistant or atypical bacteria, or a higher risk of developing complications. Antibiotic prophylaxis - Only start a trial of antibiotic prophylaxis on specialist advice - When considering antibiotic prophylaxis, discuss the possible benefits (reduced exacerbations), harms (increased antimicrobial resistance, adverse effects and interactions with other medicines) and the need for regular review with the patient. - Where a person is receiving antibiotic prophylaxis, treatment should be with an antibiotic from a different class. *Local consultant microbiologist recommendation (Dr John Clark, EStH; Dr Marina Basarab, SGH)
	1. Amoxicillin OR (preferred if pregnant)	500mg TDS	7-14 days	
	Doxycycline OR	200mg STAT then 100mg OD	7-14 days	
	Clarithromycin	500mg BD	7-14 days	
	Adults aged 18 years & over - alternative choice oral antibiotics (if person at higher risk of treatment failure) empirical treatment:			
	2. Co-amoxiclav OR	500/125mg TDS	7-14 days	
	Levofloxacin (consider safety issues)	500mg OD/BD	7 - 14 days	
	Children & young people under 18 years Send a sputum sample for culture and susceptibility testing and start empirical treatment:			
	1. Amoxicillin OR	1-11 months:125mg TDS ^{BNFc} 1-4 years: 250mg TDS 5-17 years: 500mg TDS	7 - 14 days	
	Clarithromycin OR	1 month - 11 years: ^{BNFc} Under 8kg: 7.5mg/kg BD 8-11kg: 62.5mg BD 12-19kg: 125 mg BD 20-29kg: 187.5mg BD 30-40 kg: 250mg BD OR 12-17 years: 250-500mg BD	7 - 14 days	
	Doxycycline (not in under 12yrs)	200mg STAT then 100mg OD ^{BNFc}	7 - 14 days	
	Children & young people under 18 years – alternative choice oral antibiotics (if person at higher risk of treatment failure) empirical treatment:			
2. Co-amoxiclav OR	1-11 months: 0.25 ml/kg of 125/31 suspension TDS ^{BNFc} 1-5 years: 5ml of 125/31 suspension TDS OR 0.25ml/kg of 125/31 suspension TDS 6-11 years: 5ml of 250/62 suspension TDS OR 0.15 ml/kg of 250/62 suspension TDS 12-17 years: 250/125mg TDS OR 500/125mg TDS	7 - 14 days		
Ciprofloxacin (on microbiologist advice only) (consider safety issues)	1-17 years: 20mg/kg BD (max. 750mg per dose) ^{BNFc}	7 - 14 days		
AND*				
Clarithromycin* OR	1 month - 11 years: ^{BNFc} Under 8kg: 7.5mg/kg BD 8-11kg: 62.5mg BD 12-19kg: 125 mg BD 20-29kg: 187.5mg BD 30-40 kg: 250mg BD OR 12-17 years: 250-500mg BD	7 - 14 days		
Doxycycline* (not in under 12yrs)	200mg STAT then 100mg OD ^{BNFc}	7 - 14 days		

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by ^{BNFc}) for further information.

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Community-acquired pneumonia Children and young people NICE Pneumonia: diagnosis and management NG250 NG250 Community acquired pneumonia in Children and Young people Visual summary	Non-severe in children:			Refer to paediatric specialist if under 1 month. In children and young people, severity is assessed by clinical judgement. Features of severe CAP may include: • Difficulty breathing • Oxygen saturation less than 90% • Raised heart rate • Grunting • Severe chest indrawing • Inability to breastfeed or drink • Lethargy • Reduced level of consciousness Note that percutaneous oxygen saturation monitors may be inaccurate in people with pigmented skin. When choosing antibiotics, take account of • the severity of symptoms or signs in children and young people • the risk of complications, for example, a relevant comorbidity (such as severe lung disease or immunosuppression) • local antimicrobial resistance and surveillance data (such as flu and Mycoplasma pneumoniae infection rates) • recent antibiotic use • previous microbiological results, including colonisation with multi-drug resistant bacteria. For children and young people with severe community acquired pneumonia: • Consider blood cultures if there are additional clinical indications such as suspected sepsis [NICE sepsis: recognition, diagnosis and early management.] • Consider sputum cultures, if possible and age appropriate, taking into account their history of antibiotic treatment, their clinical trajectory, the presence of any comorbidities, any recent hospitalisation and the likelihood of getting a good quality sputum sample. • Do not routinely use urinary antigen tests. Explain to parents or carers of children with CAP that after starting treatment their child's symptoms should steadily improve, although the rate of improvement will vary and some symptoms will persist after stopping antibiotics. For most children: • fever (without use of antipyretics) and difficulty breathing should have resolved within 3 to 4 days • cough should gradually improve but may persist for up to 4 weeks after discharge and does not usually require further review if the child is otherwise well. Advise parents or carers of children with CAP to seek further advice if there is persisting fever combined with: • increased work of breathing or • reduced fluid intake for children or poor feeding for infants or • unresolving fatigue. If intravenous antibiotics required, or alternative antibiotics required for severe CAP or penicillin allergy, consult microbiologist.
	1. Amoxicillin (caution in penicillin allergy)	1 to 2 months: 125mg TDS 3 to 11 months: 125mg TDS 1 to 4 years: 250mg TDS 5 to 11 years: 500mg TDS 12 to 17 years: 500mg TDS (higher doses can be used - see BNFc)	5 days 3 days 3 days 3 days 5 days	
	Non-severe in children – alternative first choice:			
	2. Clarithromycin	1 to 2 months: • under 8 kg, 7.5 mg/kg BD 3 months to 11 years: • under 8 kg, 7.5mg/kg BD • 8 to 11 kg, 62.5mg BD • 12 to 19 kg, 125mg BD • 20 to 29 kg, 187.5mg BD • 30 to 40 kg, 250mg BD 12 to 17 years: 250mg to 500mg BD BNFc	5 days 3 days 3 days 3 days 3 days 5 days	
	OR			
	Erythromycin (preferred if pregnant)	8 to 11 years: 250mg to 500mg QDS 12 to 17 years: 250mg to 500mg QDS BNFc	3 days 5 days	
	OR			
	Doxycycline (not in under 12yrs)	12 to 17 years: 200mg on first day, then 100 mg OD for 4 days BNFc	5 days	
	Severe in children:			
	Co-amoxiclav (caution in penicillin allergy)	1 to 11 months: • 0.5 ml/kg of 125/31 suspension TDS 1 to 5 years: • 10 ml of 125/31 suspension TDS or • 0.5 ml/kg of 125/31 suspension TDS or • 5 ml of 250/62 suspension TDS 6 to 11 years: • 10 ml of 250/62 suspension TDS or • 0.3 ml/kg of 250/62 suspension TDS 12 to 17 years, 500/125mg TDS BNFc	5 days 5 days 5 days 5 days 5 days 5 days 5 days	
AND (if atypical pathogens suspected)				
Clarithromycin	1 to 2 months: • under 8 kg, 7.5 mg/kg BD 3 months to 11 years: • under 8 kg, 7.5mg/kg BD • 8 to 11 kg, 62.5mg BD • 12 to 19 kg, 125mg BD • 20 to 29 kg, 187.5mg BD • 30 to 40 kg, 250mg BD 12 to 17 years: 250mg to 500 mg BD BNFc	5 days 5 days 5 days 5 days 5 days 5 days		
OR				
Erythromycin (preferred if pregnant)	8 to 11 years: 250mg to 500mg QDS 12 to 17 years: 250mg to 500mg QDS BNFc	5 days 5 days		

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by [BNFc](#)) for further information.

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS																		
Community-acquired pneumonia Adults in primary care NICE Pneumonia: diagnosis and management NG250 NG250 Community acquired pneumonia – Adults in primary care Visual summary	Low severity in adults:			If sepsis is suspected, assess and manage the person in line with NICE's guideline on sepsis: recognition, diagnosis and early management. Severity is based on clinical judgement guided by mortality risk score CRB65. Each CRB65 parameter scores one: • Confusion (Antimicrobial MT<8, or new disorientation in person, place or time) • Respiratory rate >30/min; • BP low systolic <90mmHg or low diastolic ≤ 60mmHg; • Age ≥ 65 Clinical judgement should always be used, as there may be situations where the mortality risk score does not align with the assessment of disease severity such as comorbidities or pregnancy. Stratify and inform shared decisions about place of care. <table><tr><th>Score</th><th>Severity</th><th>Potential place of care</th></tr><tr><td>0</td><td>Low</td><td>Primary care-led services and safety netting advice</td></tr><tr><td>1</td><td>Moderate</td><td>Primary care-led services and safety netting advice or referral to: • Virtual ward • Same day emergency care unit (SDEC) • Hospital at home service • Inpatient care </td></tr><tr><td>2</td><td>Moderate</td><td>Refer to hospital</td></tr><tr><td>3</td><td>High</td><td>Refer to hospital</td></tr><tr><td>4</td><td>High</td><td>Refer to hospital</td></tr></table> When considering a virtual ward, SDEC unit or hospital at home service, make a shared decision with the person (and their family/carers, where appropriate) about the most appropriate place of care, taking into account: • The person's preferences and support network • Any advanced care plan or treatment escalation plan • Clinical risks, including any comorbidities or frailty • The safety and suitability of the person's home environment Start antibiotic treatment as soon as possible after establishing a diagnosis. When choosing an antibiotic, take account of: • The disease severity • The risk of complications, e.g. a relevant comorbidity (such as severe lung disease or immunosuppression) • Recent antibiotic use • Previous microbiological results, including colonisation with multi-drug resistant bacteria Give oral antibiotics first line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics. Stop antibiotics after 5 days unless microbiological results suggest a longer course is needed or the person is not clinically stable. Reassess people if symptoms or signs do not improve as expected or worsen rapidly or significantly.	Score	Severity	Potential place of care	0	Low	Primary care-led services and safety netting advice	1	Moderate	Primary care-led services and safety netting advice or referral to: • Virtual ward • Same day emergency care unit (SDEC) • Hospital at home service • Inpatient care	2	Moderate	Refer to hospital	3	High	Refer to hospital	4	High	Refer to hospital
	Score	Severity	Potential place of care																			
	0	Low	Primary care-led services and safety netting advice																			
	1	Moderate	Primary care-led services and safety netting advice or referral to: • Virtual ward • Same day emergency care unit (SDEC) • Hospital at home service • Inpatient care																			
	2	Moderate	Refer to hospital																			
	3	High	Refer to hospital																			
	4	High	Refer to hospital																			
	1. Amoxicillin (caution in penicillin allergy)	500mg TDS (higher doses can be used - see BNF)	5 days																			
	Low severity in adults– alternative first choice:																					
	Doxycycline (not in pregnancy)	200mg STAT then 100mg OD	5 days																			
	OR																					
	Clarithromycin	500mg BD	5 days																			
	OR																					
	Erythromycin (preferred if pregnant)	500mg QDS	5 days																			
	Moderate severity in adults:																					
	1. Amoxicillin (caution in penicillin allergy)	500mg TDS (higher doses can be used - see BNF)	5 days																			
AND (if atypical pathogens suspected)																						
Clarithromycin	500mg BD	5 days																				
OR																						
Erythromycin (preferred if pregnant)	500mg QDS	5 days																				
Moderate severity in adults – alternative first choice:																						
Doxycycline (not in pregnancy)	200mg STAT then 100mg OD	5 days																				
OR																						
Clarithromycin	500mg BD	5 days																				
High severity in adults:																						
1. Co-amoxiclav (caution in penicillin allergy)	500/125mg TDS	5 days																				
AND (if atypical pathogens suspected)																						
Clarithromycin	500mg BD	5 days																				
OR																						
Erythromycin (preferred if pregnant)	500mg QDS	5 days																				
High severity in adults – alternative first choice:																						
Levofloxacin (consider safety issues)	500mg BD	5 days																				

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by [BNFc](#)) for further information.

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
HOSPITAL ACQUIRED PNEUMONIA - Hospital-acquired pneumonia develops 48 hours or more after hospital admission - It includes people who have been discharged from hospital within the last 7 to 10 days.				
Hospital-acquired pneumonia NICE Pneumonia: diagnosis and management NG250 NG250 Hospital-acquired pneumonia Visual summary	Non-severe and NOT higher risk of resistance:			Refer to paediatric specialist if under 1 month.
	1. Co-amoxiclav (caution in penicillin allergy)	1 to 11 months: • 0.5ml/kg of 125/31 suspension TDS 1 to 5 years: • 10ml of 125/31 suspension TDS or • 0.5ml/kg of 125/31 suspension TDS or • 5ml of 250/62 suspension TDS 6 to 11 years: • 10ml of 250/62 suspension TDS or • 0.3ml/kg of 250/62 suspension TDS 12 to 17 years: 500/125mg TDS BNFc 18 years+, 500/125mg TDS	5 days then review	Ventilator associated pneumonia is excluded in this guideline. Higher risk of resistance includes symptoms or signs starting more than 5 days after hospital admission, relevant comorbidity such as severe lung disease or immunosuppression, recent use of broad spectrum antibiotics, colonisation with multi-drug resistant bacteria and recent contact with health or social care setting before current admission. Start antibiotic treatment as soon as possible after establishing a diagnosis of HAP.
	Non-severe and NOT higher risk of resistance – ADULTS alternative first choice:			When choosing an antibiotic(s), take account of: - disease severity (based on clinical judgement) - number of days in hospital before onset of symptoms - the risk of developing complications, for example if the person has a relevant comorbidity (such as severe lung disease or immunosuppression) - recent antibiotic use - recent microbiological results, including colonisation with multi-drug resistant bacteria - recent contact with health or social care setting before current admission - the risk of adverse effects with broad spectrum antibiotics, including <i>Clostridium difficile</i> infection.
	2. Doxycycline (not in under 12yrs or pregnancy) OR Cefalexin (caution in penicillin allergy)	200mg STAT then 100mg OD 500 mg BD or TDS (can increase to 1 to 1.5g TDS or QDS)	5 days then review 5 days then review	
	Non-severe and not higher risk of resistance – CHILDREN alternative first choice:			Give oral antibiotics first line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics. Stop antibiotics after 5 days unless microbiological results suggest a longer course is needed or the person is not clinically stable. Reassess people if symptoms or signs do not improve as expected or worsen rapidly or significantly. Consider sending a sample (sputum, nasopharyngeal swab or tracheal aspirate) for processing where appropriate/possible.
	Clarithromycin	1 month to 11 years: • Under 8 kg, 7.5 mg/kg BD • 8 to 11 kg, 62.5 mg BD • 12 to 19 kg, 125 mg BD • 20 to 29 kg, 187.5 mg BD • 30 to 40 kg, 250 mg BD 12 to 17 years: 500 mg BD BNFc	5 days then review	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by [BNFc](#)) for further information.

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
URINARY TRACT INFECTIONS <i>Note: As antibiotic resistance and Escherichia coli bacteraemia in the community is increasing, use nitrofurantoin first line, always give safety net and self-care advice, and consider risks for resistance. Give TARGET UTI leaflet, and refer to the PHE UTI guidance for diagnostic information.</i>				
Uncomplicated lower UTI (i.e. no fever or flank pain) in men & non-pregnant women 16 years & over NICE NG109: Urinary tract infection (lower) visual summary	1. Nitrofurantoin OR <i>If low risk of resistance:</i> Trimethoprim	100mg m/r BD (BD dose preferred due to increased compliance) OR 50mg i/r QDS 200mg BD	Women: 3 days Men: 7 days	Self-care advice: - Advise paracetamol or ibuprofen for pain & drinking enough fluid to avoid dehydration. - No evidence for cranberry products or urine alkalinising agents to treat lower UTI. - When considering antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data. BNF: Nitrofurantoin may be used with caution if eGFR 30-44ml/min to treat uncomplicated lower UTI caused by suspected or proven multidrug resistant bacteria and only if potential benefit outweighs risk. Low risk of resistance: younger women with acute UTI and no risk. Risk factors for increased resistance include: - care-home resident; - recurrent UTI; - hospitalisation for >7 days in the last 6 months; - unresolving urinary symptoms; - recent travel to a country with increased resistance; - previous UTI resistant to trimethoprim, cephalosporins, or quinolones. If risk of resistance: send urine for culture and susceptibilities; safety net. Women: Treat women with severe/≥3 symptoms. Women <65 years (mild/≤2 symptoms): pain relief, and consider back up antibiotic (to use if no improvement in 48 hours or symptoms worsen at any time) or immediate antibiotic If urine not cloudy, 97% NPV of no UTI. If urine cloudy, use dipstick to guide treatment: nitrite, leukocytes, blood all negative 76% NPV; nitrite plus blood or leukocytes 92% PPV of UTI. Men: - Immediate antibiotic. Men <65 years: consider prostatitis and send MSU, or if symptoms mild or non-specific, use negative dipstick to exclude UTI. - Nitrofurantoin is not recommended for men with suspected prostate involvement because it is unlikely to reach therapeutic levels in the prostate. All patients >65 years: treat if fever >38°C, or 1.5°C above base twice in 12 hours, and >1 other symptom. TARGET UTI SIGN 160: Management of suspected bacterial lower urinary tract infection in adult women
	If treatment failure always perform culture			
	Consider alternative diagnoses and follow recommendations in the acute pyelonephritis or acute prostatitis sections, basing antibiotic choice on recent culture and susceptibility results.			
	If first line unsuitable or eGFR <45ml/min & MSU indicates susceptible:			
	Pivmecillinam OR If high resistance risk & MSU indicates susceptible: Fosfomycin	400mg STAT then 200mg TDS 3g STAT	Women: 3 days Men: 7 days Single dose	
UTI in pregnancy NICE NG109: Urinary tract infection (lower) visual summary	Send MSU for culture; start antibiotics in all with significant bacteriuria, even if asymptomatic:			- Pregnant women: immediate antibiotic. Treatment of asymptomatic bacteriuria in pregnant women: choose from nitrofurantoin (avoid at term), amoxicillin or cefalexin based on recent culture and susceptibility results. - Review treatment on results of any available previous MSU. SPC: Short-term use of nitrofurantoin in pregnancy is unlikely to cause problems to the foetus but avoid at term due to possible risk of neonatal haemolysis. SIGN 160: Management of suspected bacterial lower urinary tract infection in adult women PHE: Urinary tract infection: diagnostic tools for primary care
	<i>If eGFR ≥45ml/min:</i> 1. Nitrofurantoin (avoid at term)	100mg m/r BD (BD dose preferred due to increased compliance) OR 50mg i/r QDS	7 days	
	Only if culture results available and susceptible:			
	2. Amoxicillin OR Cefalexin	500mg TDS 500mg BD	7 days 7 days	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by [BNF](#)) for further information.

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
UTI in patients with catheters NICE NG113: Urinary tract infection (catheter-associated) visual summary	First choice non-pregnant women & men if no upper UTI symptoms:			Self-care advice: - Advise paracetamol for pain and drinking enough fluids to avoid dehydration. Antibiotic treatment is not routinely needed for asymptomatic bacteriuria in people with a urinary catheter. - Consider removing or, if not possible, changing the catheter if it has been in place for more than 7 days. But do not delay antibiotic treatment Offer an antibiotic for a symptomatic infection. When prescribing antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data. Refer to NICE NG113 visual summary for suitable antibiotic options & for children's recommended antibiotic options. - Do not routinely offer antibiotic prophylaxis to people with a short-term or long-term catheter or for catheter change unless there is a history of catheter-change-associated UTI or trauma. Non-pregnant women & men with upper UTI symptoms: Treat as per pyelonephritis. Pregnant women with upper UTI symptoms: Refer to secondary care.
	If eGFR ≥45ml/min: Nitrofurantoin OR If low risk of resistance: Trimethoprim OR Only if culture results available and susceptible: Amoxicillin	100mg m/r BD (BD dose preferred due to increased compliance) OR 50mg i/r QDS 200mg BD 500mg TDS	7 days 7 days 7 days	
	Second choice non-pregnant women & men if no upper UTI symptoms:			
	Pivmecillinam	400mg STAT then 200mg TDS	7 days	
Acute prostatitis NICE NG110: Prostatitis (acute) visual summary	Guided susceptibilities when available:			Self-care advice: - Advise paracetamol (+/- low-dose weak opioid) for pain, or ibuprofen if preferred and suitable. - Send MSU for culture and start antibiotics. - Advise that duration of acute prostatitis may last several weeks. - Review antibiotic treatment after 14 days and either stop antibiotics or continue for a further 14 days if needed (based on assessment of history, symptoms, clinical examination, urine and blood tests). - Quinolones achieve high prostate concentrations. NICE CKS: Consider prostatitis if patient has the following: - perineal, penile or rectal pain - acute urinary retention - obstructive voiding symptoms - low back pain - pain on ejaculation - tender, swollen, warm prostate
	1.Ciprofloxacin OR Ofloxacin (consider safety issues) OR Trimethoprim (if unable to take quinolone)	500mg BD 200mg BD 200mg BD	 14 days then review	
	After discussion with specialist:			
	2.Levofloxacin (consider safety issues) OR Co-trimoxazole (consider safety issues)	500mg OD 960mg BD	14 days then review 14 days then review	
Acute pyelonephritis NICE NG111: Pyelonephritis (acute) visual summary	Send MSU and start:			Self-care advice: - Advise paracetamol (+/- low-dose weak opioid) for pain for people over 12. - Offer an antibiotic. - When prescribing antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data. - If admission not needed, send MSU for culture and susceptibility testing, and start antibiotics. - If no response within 24 hours, seek advice. If ESBL risk, and on advice from a microbiologist, consider IV antibiotic via OPAT. CKS: Although ciprofloxacin, and co-amoxiclav are associated with an increased risk of <i>Clostridium difficile</i>, MRSA, and other antibiotic-resistant infections, this has to be balanced against the risk of treatment failure and consequent serious complications with the use of narrow spectrum antibiotics. Refer pregnant women to secondary care. NICE CKS: Consider pyelonephritis if patient has the following: - Kidney pain/tenderness in back under ribs - New/different myalgia, flu-like illness - Shaking chills (rigors) or temperature ≥37.9°C (or <36°C in people aged over 65 years) - Nausea/vomiting
	Ciprofloxacin (consider safety issues) OR Cefalexin	500mg BD 500mg BD/TDS up to 1g-1.5g TDS/QDS for severe infections	7 days 7-10 days	
	OR Only if culture results available and susceptible: Co-amoxiclav OR Only if culture results available and susceptible: Trimethoprim	 500/125mg TDS 200mg BD	 7-10 days 14 days	

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS	
UTI in Children NICE CG 54: Urinary tract infection in under 16s: diagnosis and management NICE NG109: Urinary tract infection (lower) visual summary	Lower UTI: Send MSU then start:			Self-care advice: - Advise paracetamol or ibuprofen for pain. Children: immediate antibiotic Child <3 months: refer urgently for assessment. Child >3 months: use positive nitrite to guide antibiotic use; send pre-treatment MSU. Imaging: refer if child <6 months, or recurrent or atypical UTI. Upper UTI: refer to paediatrics to: obtain a urine sample for culture; assess for signs of systemic infection; consider systemic antimicrobials. - For alternative dosing see BNFC.	
	If low risk of resistance: Trimethoprim	6 months-11 years: BNFc 4mg/kg (max. 200mg) BD 12-15 years: 200mg BD	3 days		
	OR				
	If eGFR ≥45ml/min: Nitrofurantoin	Immediate release: BNFc 3 months-11 years: 750micrograms/kg QDS 12-15 years: 50mg QDS Modified release: BNFc 12-15 years: 100mg BD	3 days 3 days		
	If culture results available and susceptible:				
	Amoxicillin	3-11 months: 125mg TDS BNFc 1-4 years: 250mg TDS 5-15 years: 500mg TDS	3 days		
	OR				
	Cefalexin	3 months -11 years: BNFc 12.5mg/kg BD 12-15 years: 500mg BD	3 days		
Recurrent UTI (prophylaxis) 16 years+: 2 in 6 months or ≥3 in a year Under 16 years: ≥2 upper UTI or 1 upper UTI plus ≥1 lower UTI or ≥3 lower UTIs in a year NICE NG112: Urinary tract infection (recurrent) visual summary	One-off dose when exposed to identifiable trigger			Refer or seek specialist advice for: - men - trans-women and people with a male urinary system - people with recurrent upper UTI - people with recurrent lower UTI if the underlying cause of recurrent UTI is unknown - pregnant people - children under 16 years - people with suspected cancer - anyone who has had surgery structurally altering the urethra For non-pregnant women, trans-men and non-binary people with a female urinary system: - First advise about behavioural and personal hygiene measures, and self-care (with D-mannose or cranberry products) to reduce the risk of UTI. - If no improvement after behavioural or personal hygiene measures or if these are not appropriate: for those who are experiencing perimenopause, menopause, or are postmenopausal, consider vaginal oestrogen (off-licence) and review within 12 months. - If no improvement after vaginal oestrogen or if it is not appropriate: consider single-dose antibiotic prophylaxis for exposure to a trigger (review within 6 months). - If no improvement after trying vaginal oestrogen, and/or prophylaxis for triggers and/or there is no identifiable trigger: consider methenamine hippurate as an alternative to daily prophylaxis, as long as any current UTI is treated (review within 6 months, and then every 12 months, or earlier if agreed with the person). - If no improvement after antiseptic prophylaxis or if it is not appropriate: consider a trial of daily antibiotic prophylaxis (review within 6 months). ***Methenamine prescribing status: Red (Prescribed and administered by a specialist) - Pregnancy Amber 2 (Initiation by a specialist and review after 6 months, then continuation prescribed in primary care) - in complicated upper or lower UTI - in men, trans women and non binary people with a male genitourinary system - in children and young people. Green (Suitable for prescribing in primary care); - in women, and trans men and non-binary people with a female urinary system, if: - they are not pregnant and - any current UTI has been adequately treated and - they have recurrent UTI that has not been adequately improved by behavioural and personal hygiene measures &/or vaginal oestrogen (if any of these have been appropriate and are applicable).	
	1. Trimethoprim	16+ years, 200mg STAT	Review all within 6 months of initiation and annually thereafter		
	OR				
	Nitrofurantoin* if eGFR over 45ml/min) (avoid at term)	16+ years, 100mg STAT			
	2. Amoxicillin**	16+ years, 500mg STAT			
	OR				
	Cefalexin**	16+ years, 500mg STAT			
	Antiseptic prophylaxis				
	Methenamine*** (See comments for prescribing status)	6-12 years, 500mg twice a day BNFc 12+ years, 1g twice a day	Review all within 6 months of initiation and annually thereafter		
	Daily antibiotic prophylaxis				
1. Trimethoprim	3-5 months, 2mg/kg NOCTE BNFc (max 100mg per dose) or 12.5mg NOCTE 6 months-5 years, 2mg/kg NOCTE (max. 100mg per dose) or 25mg NOCTE 6 years -11years, 2mg/kg NOCTE (max 100mg per dose) or 50mg NOCTE 12+ years, 100mg NOCTE	Review all within 6 months of initiation and annually thereafter			
OR					
Nitrofurantoin* if eGFR over 45ml/min) (avoid at term)	3months-11years, 1mg/kg NOCTE 12+ years, 50-100mg NOCTE BNFc				
2. Amoxicillin**	3months-11months, 62.5mg NOCTE 1-4years, 125mg NOCTE BNFc 5-15 years, 250mg NOCTE 16 years+, 250mg NOCTE				
OR					
Cefalexin**	3months-15years, 12.5mg/kg NOCTE (max 125mg per dose) BNFc 16+ years, 125mg NOCTE				
* Off label use for preventing recurrent upper UTI or complicated lower UTI ** Off label use for preventing recurrent UTI					

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by [BNFc](#)) for further information.

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
MENINGITIS / SEPTICAEMIA				
Suspected meningococcal disease NICE CG 102: Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management	Benzylpenicillin IV or IM	Child <1yr: 300mg ^{BNFc} Child 1-9 years: 600mg Adults/child 10+ years: 1.2g	STAT dose; give IM if vein cannot be accessed	• Transfer all patients to hospital immediately. • If time before hospital admission, if suspected meningococcal septicaemia or non-blanching rash, give IV benzylpenicillin as soon as possible. • Do not give IV antibiotics if there is a definite history of anaphylaxis; rash is not a contraindication. • CKS: Bacterial meningitis and meningococcal disease are notifiable diseases in England and Wales.
Prevention of secondary case meningitis	• To notify a suspected case of meningococcal disease or discuss any queries regarding the management of contacts, please contact UKHSA South London Health Protection Team (SL HPT) ☎ 0344 326 2052 (in & out of hours) or 📠 0344 326 7255. • The South London Health Protection Team (SL HPT) will identify close contacts requiring prophylaxis & any vaccination needs and will advise the GP accordingly.			

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
GASTRO-INTESTINAL TRACT INFECTIONS				
Oral Candidiasis CKS Candida	Miconazole oral gel	4 - 23 months: 1.25ml of 20mg/g ^{BNFc} QDS (hold in mouth after food) ≥2 years: 2.5ml of 20mg/g ^{BNFc} QDS (hold in mouth after food)	7 days; continue for 7 days after resolved	Self-care advice: - Miconazole oral gel is available OTC (not licensed for use in children under 4 months of age or during first 5–6 months of life of an infant born pre-term, patients with liver dysfunction and patients taking warfarin or simvastatin). See SmPC. - Topical azoles are more effective than topical nystatin. - Oral candidiasis is rare in immunocompetent adults; consider undiagnosed risk factors, including HIV. If extensive/severe candidiasis, use 50mg fluconazole If HIV or immunocompromised, use 100mg fluconazole.
	<i>If not tolerated:</i> Nystatin suspension	1ml; 100,000 units/mL ^{BNFc} QDS (half in each side)	7 days; continue for 2 days after resolved	
	Fluconazole capsules	50mg/100mg OD ^{BNFc}	7-14 days	
Helicobacter pylori NICE CG184: GORD and dyspepsia in adults: investigation and management PHE: Helicobacter pylori in dyspepsia: test and treat	First line & first relapse & no penicillin allergy: PPI plus TWO antibiotics:			Always test for <i>H. pylori</i> before giving antibiotics. Leave a 2-week washout period after proton pump inhibitor (PPI) use before testing for <i>H. pylori</i> with a carbon-13 urea breath test (UBT) or a stool antigen test (STA), or laboratory-based serology where its performance has been locally validated. Treat all positives, if known duodenal ulcers (DU), Gastric ulcer (GU), or low grade mucosa-associated lymphoid tissue (MALT) lymphoma (MALToma). NNT in non-ulcer dyspepsia (NUD): 14. Do not offer <i>H.pylori</i> eradication for GORD. Also note: Both <i>H. pylori</i> and NSAIDs are independent risk factors for peptic ulcers, so eradication will not remove all risk. Do not use clarithromycin, metronidazole or quinolone if used in the past year for any infection. Penicillin allergy: use PPI PLUS clarithromycin PLUS metronidazole. If previous clarithromycin, use PPI PLUS bismuth salt PLUS metronidazole PLUS tetracycline hydrochloride. Relapse and previous metronidazole and clarithromycin: use PPI PLUS amoxicillin PLUS either tetracycline OR levofloxacin (if tetracycline not tolerated). Retest for <i>H. pylori</i> : post DU/GU, or relapse after second-line therapy, using UBT or SAT, consider referral for endoscopy and cultures.
	Omeprazole OR Lansoprazole AND	20mg BD 30mg BD	7 days	
	Amoxicillin AND	1g BD		
	Clarithromycin OR	500mg BD		
	Metronidazole	400mg BD		
	Alternative Second line (for patients who have received previous treatment with clarithromycin and metronidazole):			
	PPI AND		7 days	
	Amoxicillin AND	1g BD		
	Tetracycline OR	500mg QDS		
	Levofloxacin	250mg BD		
Third line (on specialist advice only):				
Oral PPI AND		10 days		
Bismuth Subsalicylate AND	525mg QDS			
Two antibacterials from notes mentioned above not previously used OR				
Rifabutin AND Furazolidone OR	400mg BD 500mg QDS			
Pylera® (Bismuth subcitrate 140mg, metronidazole 125mg, tetracycline 125mg per capsule)	Three capsules QDS			
Penicillin allergy				
PPI AND		7 days		
Clarithromycin AND	500mg BD			
Metronidazole	400mg BD			

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS	
Helicobacter pylori NICE CG184: GORD and dyspepsia in adults: investigation and management PHE: Helicobacter pylori in dyspepsia: test and treat	Penicillin allergy and previous clarithromycin			See previous page.	
	Oral PPI AND Bismuth Subsalicylate AND Metronidazole AND Tetracycline OR Pylera® (Bismuth subcitrate 140mg, metronidazole 125mg, tetracycline 125mg per capsule)	525mg QDS 400mg BD 500mg QDS Three capsules QDS	7 days 10 days		
	Penicillin allergy second line				
	PPI AND Metronidazole AND Levofloxacin	400mg BD 250mg BD	7 days		
	Alternative second line (in patients who have received previous treatment with a fluroquinolone)				
	PPI AND Bismuth Subsalicylate AND Metronidazole AND Tetracycline OR Pylera® (Bismuth subcitrate 140mg, metronidazole 125mg, tetracycline 125mg per capsule)	525mg QDS 400mg BD 500mg QDS Three capsules QDS	7 days 10 days		
	Third line (on specialist advice only):				
	PPI AND Bismuth Subsalicylate AND Rifabutin OR Furazolidone	525mg QDS 150mg BD 200mg BD	10 days		
	- Refer previously healthy children with acute painful or bloody diarrhoea to exclude E.coli 0157 infection. Antibiotics are usually not indicated unless systemically unwell. - If systemically unwell and campylobacter suspected (e.g. undercooked meat and abdominal pain), consider clarithromycin 250-500mg BD for 5-7 days if treated early (within 3 days). - If giardia is confirmed or suspected: tinidazole 2g STAT is the treatment of choice. Food poisoning is notifiable. Notify and seek advice on exclusion from the South London Health Protection Unit, ☎ 0344 326 2052.				

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ILLNESS	DRUG OPTION	DOSE	DURATION	COMMENTS
<i>Clostridioides difficile</i> NICE <i>Clostridioides difficile</i> NG199 NG199 Visual summary Updated March 2022	First-line for first episode of mild, moderate or severe:			- For suspected or confirmed <i>C. difficile</i> infection, see Public Health England's guidance on diagnosis and reporting. Assess: whether it is a first or further episode, severity of infection, individual risk factors for complications or recurrence (such as age, frailty or comorbidities). Existing antibiotics: review and stop unless essential. If still essential, consider changing to one with a lower risk of <i>C. difficile</i> infection. - Review the need to continue: proton pump inhibitors, other medicines with gastrointestinal activity or adverse effects (such as laxatives), medicines that may cause problems if people are dehydrated (such as NSAIDs). - Do not offer antimotility medicines such as loperamide. - Offer an oral antibiotic to treat suspected or confirmed <i>C. difficile</i> infection. - For adults, consider seeking prompt specialist advice from a microbiologist or infectious diseases specialist before starting treatment. - For children and young people, treatment should be started by, or after advice from, a microbiologist, paediatric infectious diseases specialist or paediatric gastroenterologist. If antibiotics have been started for suspected <i>C. difficile</i> infection, and subsequent stool sample tests do not confirm infection, consider stopping these antibiotics. - For detailed information click on the visual summary.
	Vancomycin	125mg QDS	10 days	
	Second-line for first episode of mild, moderate or severe if vancomycin ineffective:			
	Fidaxomicin (on microbiologist advice only)	200mg BD	10 days	
	For further episode within 12 weeks of symptom resolution (relapse):			
	Fidaxomicin (on microbiologist advice only)	200mg BD	10 days	
	For further episode more than 12 weeks after symptom resolution (recurrence):			
	Vancomycin OR Fidaxomicin(on microbiologist advice only)	125mg QDS 200mg BD	10 days 10 days	
For alternative antibiotics if first- and second-line antibiotics are ineffective or for life-threatening infection seek specialist advice (see visual summary)				
Traveller's diarrhoea	<i>Stand-by:</i> Azithromycin (unlicensed)	500mg OD	1-3 days	- Prophylaxis rarely, if ever, indicated. Prophylactic medication solely in anticipation of the onset of an ailment outside the UK should be given on a private prescription. - Consider stand-by antimicrobial only for patients at high risk of severe illness, or visiting high risk areas. - Refer to https://nathnac.net/, CKS or BNF.
	<i>Prophylaxis/treatment:</i> Bismuth subsalicylate (Pepto-Bismol®)	2 tablets QDS	2 days	
Acute Diverticulitis CKS Diverticular disease NICE diverticular disease NICE Diverticulitis NG147: antimicrobial prescribing visual summary	First choice if systemically unwell, immunosuppressed or with significant comorbidities:			Self-care advice: - If patient is systemically well, consider not prescribing antibiotics, offer diet and lifestyle advice (see NICE guidance for recommendations), and advise the person to re-present if symptoms persist or worsen. - Offer antibiotics if systemically unwell or immunosuppressed or with significant comorbidities but does not meet the criteria for referral for suspected complicated acute diverticulitis - Advise on the use of analgesia, such as paracetamol as needed. - Advise the patient to avoid NSAIDs and opioid analgesia (such as codeine) if possible, due to the potential increased risk of diverticular perforation (see CKS for further information) - Recommend clear liquids only, with a gradual reintroduction of solid food if symptoms improve over the following 2–3 days (CKS) - Consider checking bloods for raised white cell count and CRP, which may suggest infection (CKS) If the person is managed in primary care, arrange a review within 48 hours, or sooner if symptoms worsen. - Arrange urgent hospital admission if symptoms persist or deteriorate despite management in primary care. Consider arranging referral to a specialist in colorectal surgery if a person is managed in primary care and has frequent or severe recurrent episodes of acute diverticulitis. *Only prescribe ciprofloxacin if switching from IV ciprofloxacin with specialist advice
	Co-amoxiclav	500/125mg TDS	5 days (a longer course may be needed based on clinical assessment)	
	Alternative first choice if penicillin allergy or co-amoxiclav unsuitable:			
	Cefalexin (caution with penicillin allergy) and Metronidazole OR Trimethoprim and Metronidazole OR Ciprofloxacin* (consider safety issues) and metronidazole	500mg BD-TDS (up to 1-1.5g TDS-QDS in severe infection) and 400mg TDS 200mg BD and 400mg TDS 500mg BD and 400mg TDS	5 days (a longer course may be needed based on clinical assessment)	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by [BNF](#)) for further information.

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
GENITAL TRACT INFECTIONS				
STI Screening	People with risk factors should be screened for chlamydia, gonorrhoea, HIV, and syphilis. Refer individual and partners to GUM. Risk factors: <25 years; no condom use; recent/frequent change of partner; symptomatic or infected partner; area of high HIV.			
Chlamydia trachomatis/ urethritis	1. Doxycycline	100mg BD	7 days	- Opportunistically screen all sexually active patients aged 15 to 24 years for chlamydia annually and on change of sexual partner. - If positive, treat index case, refer to GUM and initiate partner notification, testing and treatment. - As single dose azithromycin has led to increased resistance in GU infections, doxycycline should be used first line for chlamydia and urethritis. - Advise patient to abstain from sexual intercourse until doxycycline is completed or for 7 days after treatment with azithromycin (14 days after azithromycin started and until symptoms resolved if urethritis). - If chlamydia, test for reinfection at 3 to 6 months following treatment if <25 years or consider if >25 years and high risk of reinfection. Second line, pregnant, breastfeeding, allergy, or intolerance: azithromycin is most effective. As lower cure rate in pregnancy, test for cure at least 3 weeks after end of treatment. - Consider referring all patients with symptomatic urethritis to GUM as testing should include <i>Mycoplasma genitalium</i> and <i>Gonorrhoea</i>. - If <i>M. genitalium</i> is proven, use doxycycline followed by azithromycin using the same dosing regimen and advise to avoid sex for 14 days after start of treatment and until symptoms have resolved.
	Second line/pregnant/breastfeeding/allergy/intolerance:			
	2. Azithromycin	1g STAT then 500mg OD	2 days (total 3 days)	
Epididymitis	Doxycycline OR	100mg BD	10-14 days	- Usually due to Gram-negative enteric bacteria in men over 35 years with low risk of STI. - If under 35 years or STI risk, refer to GUM.
	Ofloxacin (consider safety issues) OR	200mg BD	14 days	
	Ciprofloxacin (consider safety issues)	500mg BD	10 days	
Vaginal candidiasis BASHH Vulvovaginal candidiasis	Clotrimazole OR	500mg pessary	STAT	Self-care advice: - Preparations for vaginal candidiasis are available OTC for adults. - All topical and oral azoles give over 80% cure. Pregnancy: avoid oral azoles, and use clotrimazole 100mg intravaginal treatment for 6 nights. Recurrent (>4 episodes per year): 150mg oral fluconazole every 72 hours for three doses induction, followed by one dose once a week for six months maintenance.
	Clotrimazole OR	100mg pessary	6 nights	
	Fluconazole (oral)	150mg capsule	STAT	
	Recurrent: Fluconazole (induction/maintenance)	150mg every 72 hours THEN 150mg once a week	3 doses 6 months	
Bacterial vaginosis BASHH Bacterial vaginosis	Oral Metronidazole OR	400mg BD OR 2g	7 days STAT	Self-care advice: - Preparations for bacterial vaginosis are available OTC that patients may find helpful. - Oral metronidazole is as effective as topical treatment, and is cheaper. - Seven days results in fewer relapses than 2g stat at four weeks. Pregnant/breastfeeding: avoid 2g dose. Treating partners does not reduce relapse.
	Metronidazole 0.75% vaginal gel OR	5g applicator at night	5 nights	
	Clindamycin 2% cream	5g applicator at night	7 nights	
Genital Herpes BASHH Anogenital herpes	Oral Aciclovir OR	400mg TDS 800mg TDS (if recurrent)	5 days 2 days	Self-care advice: - Advise saline bathing, analgesia, or topical lidocaine for pain, and discuss transmission. First episode: treat within five days if new lesions or systemic symptoms, and refer to GUM. Recurrent: self-care if mild, or immediate short course antiviral treatment, or suppressive therapy if more than six episodes per year.
	Valaciclovir OR	500mg BD	5 days	
	Famciclovir	250mg TDS 1g BD (if recurrent)	5 days 1 day	

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Gonorrhoea	Ceftriaxone	1000mg IM	STAT	- Antibiotic resistance is now very high. - Use IM ceftriaxone if susceptibility not known prior to treatment. - Use Ciprofloxacin only if susceptibility is known prior to treatment and the isolate is sensitive to ciprofloxacin at all sites of infection. - Refer to GUM. - Test of cure is essential.
	OR Ciprofloxacin (only if known to be sensitive & consider safety issues)	500mg	STAT	
Trichomoniasis B A S H H Trichomoniasis	Metronidazole	400mg BD OR 2g (more adverse effects)	5-7 days STAT	- Oral treatment needed as extravaginal infection common. - Treat partners, and refer to GUM for other STIs. Pregnant/breastfeeding: avoid 2g single dose metronidazole; clotrimazole for symptom relief (not cure) if metronidazole declined.
	Pregnancy, to treat symptoms:			
	Clotrimazole	100mg pessary at night	6 nights	
Pelvic Inflammatory Disease BASHH PID	1. Ceftriaxone AND	1000mg IM STAT	Single dose	- Refer women and sexual contacts to GUM. - Raised CRP supports diagnosis, absent pus cells in HVS smear good negative predictive value. Exclude: ectopic pregnancy, appendicitis, endometriosis, UTI, irritable bowel, complicated ovarian cyst, functional pain. - Moxifloxacin has greater activity against likely pathogens, but always test for gonorrhoea, chlamydia and Mycoplasma genitalium. - If <i>M. genitalium</i> tests positive use moxifloxacin.
	Metronidazole AND	400mg BD	14 days	
	Doxycycline	100mg BD	14 days	
	2. Metronidazole	400mg BD	14 days	
	AND	400mg BD	14 days	
	Ofloxacin (consider safety issues)			
	OR			
	Moxifloxacin ALONE (first line for <i>M. Genitalium</i> associated PID) (consider safety issues)	400mg OD	14 days	

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South West London

ILLNESS	DRUG	DOSE	DURATION	COMMENTS
SKIN / SOFT TISSUE INFECTIONS Refer to RCGP Skin Infections online training. For MRSA, discuss therapy with microbiology.				
Impetigo NICE NG153 Impetigo: antimicrobial prescribing NG153 visual summary	Topical antiseptic:			• Localised non-bullous impetigo: consider initial treatment with hydrogen peroxide 1% cream (other topical antiseptics are available for superficial skin infections, but no evidence for these was found) • Widespread non-bullous impetigo: offer a short course of a topical or oral antibiotic, taking account of prescribing considerations • Bullous impetigo, or systemically unwell, or at high risk of complications: offer a short course of an oral antibiotic • When prescribing, take into account: ➢ that topical and oral antibiotics are both effective at treating impetigo ➢ the person's preferences, including practicalities of administration and possible adverse effects ➢ that antimicrobial resistance can develop rapidly with extended or repeated use of topical antibiotics ➢ local antimicrobial resistance data • A 5-day course is appropriate for most people with impetigo, but can be increased to 7 days based on clinical judgment, depending on the severity and number of lesions. • Do not offer combination treatment with a topical and oral antibiotic to treat impetigo (not more effective, risk adverse effects and resistance) • Consider referral to specialist or hospital if: ➢ Symptoms or signs suggest serious illness e.g. cellulitis ➢ Immunocompromised patient with widespread impetigo ➢ Bullous impetigo in babies ➢ Impetigo recurring frequently ➢ Systemically unwell ➢ High risk of complications
	Hydrogen peroxide	1% cream BD-TDS ^{BNFc}	5 days	
	First-choice topical antibiotic if hydrogen peroxide unsuitable (for example, if impetigo is around eyes) or ineffective:			
	Fusidic acid	2% cream TDS ^{BNFc}	5 days	
	Alternative topical antibiotic if fusidic acid resistance suspected or confirmed:			
	Mupirocin	2% ointment TDS ^{BNFc}	5 days	
	First-choice oral antibiotic:			
	Flucloxacillin	500mg QDS ^{BNFc}	5 days	
	Alternative oral antibiotics if penicillin allergy or flucloxacillin unsuitable:			
Clarithromycin OR	250mg BD (up to 500mg BD for severe infections) ^{BNFc}	5 days		
Erythromycin (preferred if pregnant)	250-500mg QDS ^{BNFc}	5 days		
Cold sores CKS Cold sores	If frequent, severe, and predictable triggers, consider oral prophylaxis:			Self-care advice: • For infrequent cold sores, antiviral creams are available OTC (licensed for adults and children). • Most resolve after 5 days without treatment. • Topical antivirals applied prodromally can reduce duration by 12-18 hours.
	Aciclovir	400mg BD ^{BNFc}	5-7 days	
PVL SA PHE PVL SA	• Panton-Valentine leukocidin (PVL) is a toxin produced by 20.8-46% of <i>S. aureus</i> from boils/abscesses. • PVL strains are rare in healthy people, but severe. • Suppression therapy should only be started after primary infection has resolved, as ineffective if lesions are still leaking. • Risk factors for PVL: recurrent skin infections; invasive infections; MSM; if there is more than one case in a home or close community (school children; military personell; nursing home residents; household contacts). • Contact microbiologist for treatment advice if required. For contact details see 'Principles of Treatment' section at start of guidance.			

ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Eczema (bacterial infection) NICE Secondary bacterial infection of eczema and other common skin conditions NG190 Visual summary	Topical antibiotic (if appropriate), for localised infections only:			• If not systemically unwell, do not routinely offer either a topical or oral antibiotic. • Manage underlying eczema and flares with treatments such as emollients and topical corticosteroids, whether antibiotics are given or not. • If systemically unwell offer an antibiotic. • Symptoms and signs of secondary bacterial infection can include: weeping, pustules, crusts, no response to treatment, rapidly worsening eczema, fever and malaise. • Not all flares are caused by a bacterial infection, so will not respond to antibiotics. • Eczema is often colonised with bacteria but may not be clinically infected. • Do not routinely take a skin swab at initial presentation. Consider sending a skin swab if the infection is worsening or not improving as expected. If the infection recurs frequently, send a skin swab and consider taking a nasal swab and starting treatment for decolonisation. • If an antibiotic is offered, when choosing between a topical or oral antibiotic, take account of patient preferences, extent and severity of symptoms or signs, possible adverse effects, and previous use of topical antibiotics because antimicrobial resistance can develop rapidly with extended or repeated use. • Consider referral or seeking specialist advice if the person has spreading infection that is not responding to oral antibiotics, is systemically unwell, is at high risk of complications, has infections that recur frequently. • Refer to hospital if there are symptoms or signs suggesting a more serious illness or condition such as necrotising fasciitis or sepsis.
	Fusidic acid 2%	TDS	5-7 days	
	First choice oral antibiotic:			
	Flucloxacillin	500mg QDS ^{BNFc}	5-7 days	
	Alternative first choice if penicillin allergy or flucloxacillin not suitable:			
	Clarithromycin	250mg BD (up to 500mg BD for severe infections) ^{BNFc}	5-7 days	
	OR Erythromycin (preferred if pregnant)	250mg–500mg QDS ^{BNFc}	5-7 days	
If there are symptoms or signs of cellulitis, see the recommendations on antibiotic choice in the cellulitis and erysipelas section of this guideline				
If MRSA suspected or confirmed – consult local microbiologist				
Acne Vulgaris NICE Acne vulgaris CKS Acne vulgaris Updated Jan 2024	Any severity, patients aged 12 years and over † (topical treatment):			• Mild to moderate acne, this includes people who have 1 or more of: ○ any number of non-inflammatory lesions (comedones) ○ up to 34 inflammatory lesions (with or without non-inflammatory lesions) ○ up to 2 nodules. • Moderate to severe acne, this includes people who have either or both of: ○ 35 or more inflammatory lesions (with or without non-inflammatory lesions) ○ 3 or more nodules. • Self-care advice: • Wash with non-alkaline synthetic detergent cleansing product (e.g. Dove® or Aveeno® moisturising bar) twice daily; do not scrub; avoid make-up. • Patient information from the British Association of Dermatologist is available here: • Do not use the following to treat acne; ○ monotherapy with a topical antibiotic ○ monotherapy with an oral antibiotic ○ combination of a topical and oral antibiotic ○ minocycline as per SWL Position Statement • Give clear information tailored to patient needs and concerns. Topics to cover include: ○ possible reasons for their acne ○ treatment options, including OTC treatments if appropriate ○ benefits and drawbacks of treatment ○ potential impact of acne ○ importance of adhering to treatment, as positive effects can take 6-8 weeks to become noticeable ○ relapses during and after treatment, including when to obtain further advice, and treatment options should a relapse occur
	Combination of adapalene/benzoyl peroxide	0.1%/2.5% or 0.3%/2.5% OD (thinly in the evening)	Assess after 12 weeks	
	OR Combination of tretinoin/clindamycin	0.025%/1% OD (thinly in the evening)		
	<u>Alternative treatment if listed options are contraindicated or refused †</u>			
	Benzoyl peroxide †	5% OD – BD		
	Mild to moderate, patients aged 12 years and over † (topical treatment):			
	Combination of benzoyl peroxide/clindamycin	3%/1% or 5%/1% OD (thinly in the evening)	Assess after 12 weeks	
Moderate to severe, patients aged 12 years and over † (topical PLUS oral treatment):				
<u>Topical treatment</u>				
Combination of adapalene/benzoyl peroxide	0.1%/2.5% or 0.3%/2.5% OD (thinly in the evening)	Assess after 12 weeks		
OR Azelaic acid *	15% gel BD or 20% cream BD			
AND <u>Oral treatment</u>				
Lymecycline	408mg OD			
OR Doxycycline	100mg OD			

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by ^{BNFc}) for further information.

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Alternative if above are contraindicated/refused: (oral treatment)		
Erythromycin	500mg BD	Assess after 12 weeks
OR		
Clarithromycin	250mg BD	
OR		
Trimethoprim (following consultant advice, off-label**)	300mg BD	
Children under 12 years:		
Combination of adapalene/benzoyl peroxide (not in under 9's)	0.1%/2.5% OD (thinly in the evening) ^{BNFc}	Review at 6-8 weeks. Continue for 3 months max
<u>Alternative treatment if above is contraindicated or refused †</u>		
Benzoyl peroxide	5% OD – BD ^{BNFc}	
AND IF NEEDED		
Erythromycin	500mg BD ^{BNFc}	
OR		
Clarithromycin	250mg BD (weight ≥ 30kg) ^{BNFc}	
Pregnant women:		
Combination of benzoyl peroxide/clindamycin (to be used with caution)	3%/1% or 5%/1% OD (thinly in the evening)	Review at 6-8 weeks. Continue for 3 months max
<u>Alternative if above is contraindicated, refused †</u>		
Benzoyl peroxide (alone)	5% OD – BD	
AND IF ORAL TREATMENT IS NEEDED		
Benzoyl peroxide	5% OD – BD	
WITH		
Erythromycin (preferred in pregnancy)	500mg BD	
OR		
Clarithromycin	250mg BD	

- Refer to a consultant dermatologist if any of the following apply:
 - there is diagnostic uncertainty
 - they have [acne conglobata](#)
 - they have nodulo-cystic acne
 - they have [acne fulminans](#) (urgent referral to hospital dermatology team to be assess within 24 hours)
- Consider referring to a consultant dermatologist if they have:
 - mild to moderate acne that has not responded to two courses of treatment
 - moderate to severe acne which has not responded to previous treatment that contains an oral antibiotic
 - acne with scarring
 - acne with persistent pigmentary changes
 - acne contributing to persistent psychological distress or a mental health disorder
- To reduce risk of skin irritation with topical treatments, start with alternate-day or short contact application (e.g. wash off after an hour).
- If a person receiving treatment for acne wishes to use hormonal contraception, consider using the combined oral contraceptive pill in preference to the progestogen-only pill
- Review treatment at 12 weeks and in those whose treatment includes an oral antibiotic, consider continuing treatment for up to 12 more weeks if their acne has not completely cleared (either oral and topical treatment, or topical only)
- Only continue antibiotic treatment for more than 6 months in exceptional circumstances. Review every 12 weeks and stop as soon as possible.
- If acne fails to respond adequately to a 12 week course of a first-line treatment option and at review the severity is:
 - mild to moderate: offer another option from the table of treatment choices. If mild to moderate acne fails to respond adequately to 2 different 12 week courses of treatment options, consider referral to a consultant dermatologist-led team
 - moderate to severe, and the treatment did not include an oral antibiotic: offer another option which includes an oral antibiotic from the table of treatment choices
 - moderate to severe, and the treatment included an oral antibiotic: consider referral to a consultant dermatologist-led team.
- Consider maintenance treatment in people with a history of frequent relapse after treatment.
- Consider a fixed combination of topical adapalene and topical benzoyl peroxide as maintenance treatment for acne. If this is not tolerated, or if 1 component of the combination is contraindicated, consider topical monotherapy with adapalene, azelaic acid, or benzoyl peroxide
- Review maintenance treatments for acne after 12 weeks to decide if they should continue.

* Useful in reducing risk of hyperpigmentation in individuals with darker skin

** See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information

PLEASE NOTE: Changes have been made post-IMOC to provide clarity, and have been annotated with †

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Leg ulcer infection NICE Leg Ulcer Infection NG152 Visual summary	First-choice oral antibiotic:			- Only offer an antibiotic when there are signs or symptoms of infection (for example, redness or swelling spreading beyond the ulcer, localised warmth, increased pain or fever). - Manage any underlying conditions to promote ulcer healing - Do not take a sample for microbiological testing at initial presentation, even if the ulcer might be infected as most leg ulcers are colonised by bacteria. - Give advice to seek medical help if symptoms or signs of infection: - Worsen rapidly or significantly at any time, or - Do not start to improve within 2 to 3 days of starting treatment - Person becomes systemically unwell or has severe pain out of proportion to the infection - If the infection is worsening, or not improving as expected, consider microbiological testing. - When microbiological results are available: - Review the antibiotic and change according to results if infection is not improving, using a narrow spectrum antibiotic if possible. - Consider referring or seeking specialist advice if the person: - Has a higher risk of complications because of comorbidities such as diabetes or immunosuppression - Has lymphangitis - Has spreading infection not responding to oral antibiotics - Cannot take oral antibiotics - Has a severe infection warranting the use of IV antibiotics - Refer to existing pathways for administration of iv antibiotics if appropriate <i>*See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information</i>
	Flucloxacillin	500mg-1g QDS (1g dose is off-label use* and is recommended for obese/severely obese patients)	7 days	
	Alternative first-choice oral antibiotics for penicillin allergy or if flucloxacillin unsuitable:			
	Doxycycline OR	200mg on first day, then 100mg OD (can be increased to 200mg OD)	7 days	
	Clarithromycin OR	500mg BD	7 days	
	Erythromycin (preferred if pregnant)	500mg QDS	7 days	
	Second-choice oral antibiotics (guided by microbiological results when available):			
Co-amoxiclav OR	500/125mg TDS	7 days		
Co-trimoxazole (in penicillin allergy, off-label use*)	960mg BD	7 days		
Insect bites and stings NICE Insect bites and stings NG182 Visual summary NICE CKS: Insect bites and stings Updated March 2022	Give self-care advice – see comments section.			Self-care advice: - Oral antihistamines and topical treatments are available from the pharmacy - Avoid scratching to reduce risk of infection - Redness and itching are common and may last up to 10 days Treat only if sign of infection, as most cases are self-limiting, most insect bites or stings will not need antibiotics. Be aware that a rapid onset skin reaction is more likely to be an inflammatory or allergic reaction rather than an infection Consider referral or seeking specialist advice for people if: - they are systemically unwell - they are severely immunocompromised, and have symptoms or signs of an infection - they have had a previous systemic allergic reaction to the same type of bite or sting - the bite or sting is in the mouth or throat, or around the eyes - it has been caused by an unusual or exotic insect - they have fever or persisting lesions associated with a bite or sting that occurred while travelling outside the UK Reassess if: - symptoms or signs of an infection develop - the person's condition worsens rapidly or significantly or they become systemically unwell - the person has severe pain out of proportion to the wound, which may indicate the presence of toxin-producing bacteria - Take account of other possible diagnoses, such as Lyme disease indicated by erythema migrans
	If there are symptoms or signs of infection, see the recommendations on antibiotic choice for cellulitis and erysipelas section of this guideline			

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Cellulitis & erysipelas NICE Cellulitis & erysipelas NG141 Visual summary	Flucloxacillin	500mg-1g QDS ^{BNFc} (1g dose is off-label*)	5-7 days	- A longer course (up to 14 days in total) may be needed based on clinical assessment. However, the skin does take time to return to normal, and full resolution at 5 to 7 days is not expected. - Consider marking extent of infection with a single-use surgical marker pen - Manage underlying conditions such as diabetes, venous insufficiency, eczema and oedema - Infection around the eyes or the nose (the triangle from the bridge of the nose to the corners of the mouth, or immediately around the eyes including periorbital cellulitis) is of more concern because of a risk of a serious intracranial infection complication. - Consider taking a swab for microbiological testing from people with cellulitis or erysipelas to guide treatment, but only if the skin is broken and: - there is a penetrating injury or - there has been exposure to water-borne organisms or - the infection was acquired outside the UK. - Reassess if: - symptoms worsen rapidly, or do not start to improve in 2 to 3 days - the person is very unwell, has severe pain, or redness or swelling beyond the initial presentation. - Do not routinely offer antibiotic prophylaxis to prevent recurrent cellulitis or erysipelas. - Refer to hospital if there are symptoms or signs of a more serious illness or condition such as orbital cellulitis, osteomyelitis, septic arthritis, necrotising fasciitis or sepsis - Consider referring or seeking specialist advice if the person: - is severely unwell or has lymphangitis - has infection near the eyes or nose - may have uncommon pathogens - has spreading infection not responding to oral antibiotics - cannot take oral antibiotics (to explore giving IV antibiotics at home or in the community if appropriate) *See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.
	Alternative first-choice antibiotics for penicillin allergy or if flucloxacillin unsuitable:			
	Clarithromycin OR	500mg BD ^{BNFc}	5-7 days	
	Erythromycin (preferred in pregnancy) OR	500mg QDS ^{BNFc}	5-7 days	
	Doxycycline (not in under 12yrs)	200mg on first day, then 100mg OD	5-7 days	
	First choice antibiotic if infection near the eyes or nose (consider seeking specialist advice):			
	Co-amoxiclav	500/125mg TDS ^{BNFc}	7 days	
	Alternative first choice antibiotic if infection near the eyes or nose for penicillin allergy or if co-amoxiclav unsuitable (consider seeking specialist advice):			
	Clarithromycin AND Metronidazole	500mg BD ^{BNFc} 400mg TDS ^{BNFc}	7 days	

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Human and Animal Bites NICE Human and Animal Bites NG184 Visual summary CKS Bites	Prophylaxis and treatment ALL:			- Seek specialist advice from a microbiologist for bites from a wild or exotic animal (including birds and non-traditional pets) or domestic animal bites (including farm animal bites) you are unfamiliar with - Manage the wound with irrigation and debridement as necessary Offer an antibiotic treatment course for human or animal bites if there are symptoms or signs of infection, such as: ➢ Increased pain ➢ Inflammation, ➢ Fever, ➢ Discharge or ➢ An unpleasant smell - Take a swab for microbiological testing if there is discharge (purulent or non-purulent) from the wound Do not offer antibiotic prophylaxis if a human or animal bite has not broken the skin. Human bite: Offer antibiotic prophylaxis if the human bite has broken the skin and drawn blood. Consider antibiotic prophylaxis if the human bite has broken the skin but not drawn blood if it is in a high-risk area or person at high risk (see below). Cat bite: Offer antibiotic prophylaxis if the cat bite has broken the skin and drawn blood. Consider antibiotic prophylaxis if the cat bite has broken the skin but not drawn blood if the wound could be deep. Dog or other traditional pet bite (excluding cat): Offer antibiotic prophylaxis if the bite has broken the skin and drawn blood if it has caused considerable, deep tissue damage or is visibly contaminated (for example, with dirt or a tooth). Consider antibiotic prophylaxis if the bite has broken the skin and drawn blood if it is in a high risk area or person at high risk. - High-risk areas include the hands, feet, face, genitals, skin overlying cartilaginous structures or an area of poor circulation - People at high risk include those at risk of a serious wound infection because of a co-morbidity (such as diabetes, immunosuppression, asplenia or decompensated liver disease) - Assess the risk of tetanus, rabies or a bloodborne viral infection and take appropriate action. - Consider referral or seeking specialist advice if, for example, the person: ➢ Is systemically unwell ➢ Has an infection after prophylactic antibiotic ➢ Cannot take or has an infection that is not responding to oral antibiotics *See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.
	Co-amoxiclav	375-625mg TDS ^{BNFc}	3 days for prophylaxis 5 days for treatment (course length can be increased to 7 days (with review) based on clinical assessment of the wound)	
	Alternative first-choice oral antibiotics for adults and young people aged 12 to 17 years for penicillin allergy or if co-amoxiclav is unsuitable:			
	Doxycycline (not in under 12yrs) AND Metronidazole	200mg STAT then 100-200mg OD ^{BNFc} 400mg TDS ^{BNFc}	3 days for prophylaxis 5 days for treatment (course length can be increased to 7 days (with review) based on clinical assessment of the wound)	
	Alternative first-choice oral antibiotics in pregnancy for penicillin allergy or if co-amoxiclav is unsuitable:			
	Seek specialist advice			
	Alternate first-choice for children under 12s for penicillin allergy or if co-amoxiclav is unsuitable			
Co-trimoxazole* (off-label) (consider safety issues)	6 weeks to 5 months: 120mg or 24mg/kg BD ^{BNFc} 6 months to 5 years: 240 mg or 24 mg/kg BD 6 years to 11 years: 480 mg or 24 mg/kg BD	3 days for prophylaxis 5 days for treatment (course length can be increased to 7 days (with review) based on clinical assessment of the wound)		
Dermatophyte infection: skin PHE Fungal skin and nail infections	Terbinafine OR Clotrimazole OR Miconazole	1% cream OD-BD ^{BNFc} 1% cream BD-TDS ^{BNFc} 2% cream BD ^{BNFc}	1-4 weeks 4 weeks (min) 2-6 weeks Continue for 1 week after healing	Self-care advice: - Topical antifungals available OTC. ➢ Terbinafine licensed in >16 years ➢ Miconazole/Clotrimazole licensed in children and adults Most cases: use terbinafine as fungicidal, treatment time shorter and more effective than with fungistatic imidazoles or undecenoates. If candida possible: use imidazole. If intractable, or scalp: send skin scrapings and if infection confirmed: use oral terbinafine or itraconazole. Scalp: oral therapy, and discuss with specialist.
	Athlete's foot only:			
	Undecenoate (topical) (e.g. Mycota®)	BD ^{BNFc}	Continue for 1 week after healing	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by ^{BNFc}) for further information.

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Dermatophyte infection: nail CKS Fungal nail infection	Take nail clippings; start therapy only if infection is confirmed.			- Prescribing of topical nail lacquer is not routinely recommended in SWL. See position statement. - Oral terbinafine is more effective than oral azole. - Liver reactions 0.1 to 1% with oral antifungals - If candida or non-dermatophyte infection is confirmed, use oral itraconazole. To prevent recurrence: apply weekly 1% topical antifungal cream to entire toe area. Children: seek specialist advice. Stop treatment when continual, new, healthy, proximal nail growth.
	Terbinafine	250mg OD ^{BNFc}	Fingers: 6 weeks Toes: 12 weeks	
	Itraconazole	200mg BD ^{BNFc}	1 week a month: Fingers: 2 courses Toes: 3 courses	
Mastitis CKS Mastitis and breast abscess	Flucloxacillin	500mg QDS ^{BNFc}	10-14 days	<i>S. aureus</i> is the most common infecting pathogen. - Suspect if woman has: a painful breast; fever and/or general malaise; a tender, red breast. Breastfeeding: oral antibiotics are appropriate, where indicated. Women should continue feeding, including from the affected breast.
	Penicillin allergy:			
	Erythromycin (preferred if pregnant) OR Clarithromycin	250-500mg QDS ^{BNFc} 500mg BD ^{BNFc}	10-14 days 10-14 days	
Varicella zoster/ chicken pox Herpes zoster/ shingles UKHSA Varicella	1. <i>For chicken pox or shingles</i> Aciclovir	800mg five times a day ^{BNFc}	7 days	Self-care advice: - Advise paracetamol for pain relief. CKS: Advise the following simple measures to help alleviate symptoms: - Encourage adequate fluid intake to avoid dehydration. - Dress appropriately to avoid overheating or shivering. - Wear smooth, cotton fabrics. - Keep nails short to minimize damage from scratching. Pregnant/immunocompromised/neonate: seek urgent specialist advice. Chickenpox: consider aciclovir if: onset of rash <24 hours, and one of the following: >14 years of age; - severe pain; - dense/oral rash; - taking steroids; - smoker. Shingles: treat if >50 years (PHN rare if <50 years) and within 72 hours of rash, or if one of the following: - active ophthalmic; - Ramsey Hunt; - eczema; - non-truncal involvement; - moderate or severe pain; - moderate or severe rash. Shingles treatment if not within 72 hours: consider starting antiviral drug up to one week after rash onset, if high risk of severe shingles or continued vesicle formation; older age; immunocompromised; or severe pain.
	2. <i>For shingles if poor compliance:</i> Valaciclovir	1g TDS ^{BNFc}	7 days	
	OR Famciclovir (not for children)	250-500mg TDS OR 750mg BD	7 days	
	1. Give self-care advice – Bathe/clean eyelids with cotton wool dipped in sterile saline or boiled (cooled) water, to remove crusting.			
Bacterial Conjunctivitis NICE Summary of antimicrobial prescribing guidance	2. Chloramphenicol	0.5% eye drops ^{BNFc} 2 hourly for 2 days then reduce frequency to TDS-QDS OR 1% eye ointment TDS – QDS OR NOCTE if using antibiotic eye drops during the day	Continue for 48 hours after resolution	Self-care advice: - Chloramphenicol available OTC for those >2 years. Treat only if severe, as most cases are viral or self-limiting. Bacterial conjunctivitis: usually unilateral and also self-limiting. It is characterised by red eye with mucopurulent, not watery discharge. 65% and 74% resolve on placebo by days 5 and 7. Third line: fusidic acid as it has less gram-negative activity. Chloramphenicol eye drops containing borax or boric acid buffers: use in children younger than 2 years
	3. Fusidic acid	1% gel BD ^{BNFc}	Continue for 48 hours after resolution	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by [BNFc](#)) for further information.

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
Blepharitis NICE Summary of antimicrobial prescribing guidance	Give self-care advice – see comments section.			Self-care advice: - Lid hygiene for symptom control, including: warm compresses; lid massage, wipes and scrubs; gentle washing; avoiding cosmetics. - Lid hygiene products are available OTC. Second line: topical antibiotics if hygiene measures are ineffective after 2 weeks. - Signs of Meibomian gland dysfunction, or acne rosacea: consider oral antibiotics. *See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information
	1. Chloramphenicol	1% eye ointment BD ^{BNFc}	6 week trial	
	2. Oxytetracycline OR Doxycycline (off label use*)	500mg BD ^{BNFc} then 250mg BD 100mg OD ^{BNFc} then 50mg OD	4 weeks (initial) 8 weeks (maintenance) 4 weeks (initial) 8 weeks (maintenance)	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by ^{BNFc}) for further information.

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ILLNESS	DRUG	DOSE	DURATION	COMMENTS
PARASITIC INFECTIONS				
Threadworm CKS Threadworm	Patients >6 months: Mebendazole (<2 years off label)	100mg BNFc	STAT dose; repeat after 2 weeks if persistent	Self-care advice: - Mebendazole is available OTC for those >2 years (not licensed in pregnancy or breast-feeding) - See hygiene measures below. - Treat household contacts at the same time AND advise hygiene measures (as below) for 2 weeks.
	Children < 6 months and pregnant or breastfeeding women:	- Hygiene measures alone for 6 weeks: - Thorough hand hygiene - Wear close fitting pants at night and change in the morning - Morning bath or shower, including perianal area - Wash sleepwear, bed linen, dust and vacuum - Cut fingernails regularly, avoid biting nails and scratching around the anus - Do not shake out items as this may distribute eggs around the room - Washing/drying in a hot cycle will kill threadworm eggs - Thoroughly dust and vacuum (including vacuuming mattresses) and clean the bathroom by 'damp-dusting' surfaces - Child <6 months, add perianal wet wiping or washes 3 hourly - For more details, contact the UK Teratology Information Service (UKTIS) on 0344 892 0909.		
Scabies NICE CKS scabies (Sept 2025) [Accessed 28.11.25] BASHH National guidelines on the management of scabies 2025	First choice			Seek specialist advice for crusted / Norwegian scabies.
	Permethrin 5% cream	Apply over whole body including face, neck, scalp and ears then wash off after 8–12 hours. If hands are washed with soap within 8 hours of application, they should be treated again with cream.	2 applications, 1 week apart	Treat all home and sexual contacts within 24 hours The dose of ivermectin may be taken at any time of the day, but no food should be taken within two hours before or after administration.
	Second choice			Persistence of pruritus or scraping lesions does not justify a second treatment with ivermectin before this date.
	Ivermectin (if between 15kg to 120kg)	200 micrograms / kg (rounded to nearest 3mg tablet)	Stat	Administration of a second dose of ivermectin within 2 weeks after the initial dose should only be considered: a) when new specific lesions occur, b) when the parasitologic examination is positive at this date.
	Third choice			In children less than 6 years of age, ivermectin tablets should be crushed before swallowing.
	Malathion 0.5% aqueous liquid	Apply over whole body, and wash off after 24 hours. If hands are washed with soap within 24 hours, they should be retreated.	2 applications, 1 week apart	
Lyme disease with erythema migrans NICE Lyme Disease NG95 PHE Summary of antimicrobial prescribing guidance CKS Lyme disease Updated July 22	Lyme disease without focal symptoms but with erythema migrans and/or non-focal symptoms			- Treat erythema migrans empirically; serology is often negative early in infection. - For treatment of other Lyme disease presentations see NICE guidance/seek specialist advice. - If symptoms worsen during treatment for Lyme disease, assess for an allergic reaction to the antibiotic. - Be aware that a Jarisch–Herxheimer reaction (~15% of patients) does not usually warrant stopping treatment - This causes a worsening of symptoms early in treatment - It can happen when large numbers of bacteria in the body are killed - It does not happen to everyone treated for Lyme disease - They should keep taking their antibiotics if their symptoms worsen and seek medical advice
	Doxycycline (For 9 years and above, unlicensed in under 12 years)	100mg BD BNFc Or 200mg OD	21 days	
	Alternative if doxycycline is not suitable (e.g. pregnancy):			
	Amoxicillin	1g TDS BNFc	21 days	
	Alternative if doxycycline and amoxicillin are not suitable:			
	Azithromycin Do not use azithromycin to treat people with cardiac abnormalities associated with Lyme disease because of its effect on QT interval	500mg OD BNFc	17 days	

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFC (BNFC indicated by [BNFc](#)) for further information.

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South West London

ILLNESS	DRUG	DOSE	DURATION	COMMENTS
DENTAL INFECTIONS				
<i>For suspected dental infections outside a dental setting. Derived from the Scottish Dental Clinical Effectiveness Programme 2011 SDCEP Guidelines.</i> <i>This guidance is not designed to be a definitive guide to oral conditions, as GPs should not be involved in dental treatment. This guidance may be followed if treatment is deemed necessary and the clinician feels competent to do so however patients presenting to non-dental primary care services with dental problems, in the first instance, should be directed to their regular dentist, or if this is not possible, to the NHS 111 service, who will be able to provide details of how to access emergency dental care.</i>				
Note: Antibiotics do not cure toothache. First line treatment is with paracetamol and/or ibuprofen; codeine is not effective for toothache.				
Mucosal ulceration and inflammation (simple gingivitis) SDCEP Dental problems	Simple saline mouthwash	½ tsp salt warm water ^{BNFc}	Always spit out after use	Self-care advice: - Simple saline mouthwash can be prepared at home. - Mouthwashes are available OTC. - Temporary pain and swelling relief can be attained with saline mouthwash. - Use antiseptic mouthwash if more severe, and if pain limits oral hygiene to treat or prevent secondary infection. - The primary cause for mucosal ulceration or inflammation (aphthous ulcers; oral lichen planus; herpes simplex infection; oral cancer) needs to be evaluated and treated.
	Chlorhexidine (Do not use within 30 mins of toothpaste)	0.2% mouthwash 1 minute BD with 10 mL ^{BNFc}	Use until lesions resolve or less pain allows oral hygiene	
	Hydrogen peroxide (spit out after use)	6% mouthwash 2-3 mins BD-TDS with 15ml in ½ glass warm water ^{BNFc}		
Acute necrotising ulcerative gingivitis	Chlorhexidine (Do not use within 30 mins of toothpaste) OR	0.2% mouthwash 1 minute BD with 10 mL ^{BNFc}	Until pain allows for oral hygiene	Self-care advice: - Mouthwashes are available OTC. - Refer to dentist for scaling and hygiene advice. - Antiseptic mouthwash if pain limits oral hygiene. - Commence metronidazole in the presence of systemic signs and symptoms.
	Hydrogen peroxide (spit out after use)	6% mouthwash 2-3 mins BD-TDS with 15ml in ½ glass warm water ^{BNFc}		
	If systemic signs and symptoms: Metronidazole	400mg TDS ^{BNFc}	3 days	
Pericoronitis SDCEP Dental problems	Metronidazole OR	400mg TDS ☺	3 days	Self-care advice: - Use antiseptic mouthwash if pain and trismus limit oral hygiene. - Mouthwashes are available OTC. - Refer to dentist for irrigation and debridement. - If persistent swelling or systemic symptoms, use metronidazole or amoxicillin.
	Amoxicillin	500mg TDS ☺	3 days	
	Chlorhexidine (Do not use within 30 mins of toothpaste) OR	0.2% mouthwash 1 minute BD with 10 mL ^{BNFc}	Until pain allows for oral hygiene	
	Hydrogen peroxide (spit out after use)	6% mouthwash 2-3 mins BD-TDS with 15ml in ½ glass warm water ^{BNFc}		
Dental abscess SDCEP Dental problems	Regular analgesia should be the first option until a dentist can be seen for urgent drainage, as repeated courses of antibiotics for abscesses are not appropriate.			Self-care advice: - Analgesia available OTC. - Repeated antibiotics alone, without drainage, are ineffective in preventing the spread of infection. Antibiotics are only recommended if there are signs of severe infection, systemic symptoms, or a high risk of complications. - Patients with severe odontogenic infections (cellulitis, plus signs of sepsis; difficulty in swallowing; impending airway obstruction) should be referred urgently for hospital admission to protect airway, for surgical drainage and for IV antibiotics. - The empirical use of cephalosporins, co-amoxiclav, clarithromycin, and clindamycin do not offer any advantage for most dental patients, and should only be used if there is no response to first line drugs. If pus is present, refer for drainage, tooth extraction, or root canal. - Send pus for investigation. If spreading infection (lymph node involvement or systemic signs, i.e. fever or malaise) ADD metronidazole. - Use clarithromycin in true penicillin allergy and, if severe, refer to hospital.
	Amoxicillin OR	500mg-1g TDS ^{BNFc}	Up to 5 days; review at 3 days	
	Penicillin V	500mg-1g QDS ^{BNFc}		
	Metronidazole	400mg TDS ^{BNFc}		
	Penicillin allergy: Clarithromycin	500 mg BD ^{BNFc}		

Note: Doses are for guidance only. Doses are oral and for adults. Refer to BNF/BNFc (BNFc indicated by ^{BNFc}) for further information.

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SOURCE DOCUMENTS

This guidance is based on:

1. **Summary of antimicrobial prescribing guidance - managing common infections** (latest review September 2024) <https://elearning.rcgp.org.uk/mod/book/view.php?id=14887>
2. Online BNF. Last updated 26th August 2026. <https://bnf.nice.org.uk/>
3. Online BNF for Children Last updated 26th August 2026. <https://bnfc.nice.org.uk/>
4. NICE Clinical Knowledge Summaries (CKS) <https://cks.nice.org.uk/>
5. In the development of these guidelines advice was sought from Microbiologists at Epsom and St Helier University Hospitals, Kingston Hospital and St George's Hospital